Medicare Claims Processing Manual

Chapter 15 - Ambulance

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10 - General Coverage and Payment Policies

(Rev.)

A3-3114, A3-3138, B3-2120, HO-236, SNF-262; PMs A-01-52, AB-00-88, AB-01-118, AB-00-127, AB-02-036, AB-02-48, AB-00-103, AB-01-185, AB-00-103, AB-94-8, AB-01-165, AB-03-007

These instructions apply to processing claims to carriers and intermediaries under the ambulance fee schedule.

General rules for coverage of ambulance services are in the Medicare Benefit Policy Manual, Chapter 10. General medical review instructions for ambulance services are in Chapter 6 of the Medicare Program Integrity Manual.

In general, effective April 1, 2002, payment is based on the level of service provided, not on the vehicle used. However, two temporary Q codes, Q3019 (Advanced Life Support

[ALS] vehicle used, emergency transport) and Q3020 (ALS vehicle used, nonemergency transport), are available during the transition period for those providers/suppliers that are mandated by local governments to only have ALS units.

Ambulance services are separately reimbursable only under Part B. Once a beneficiary is admitted to a hospital, Critical Access Hospitals (CAH), or Skilled Nursing Facility (SNF), it may be necessary to transport the patient to another hospital or other site for specialized testing because the inpatient facility does not have the capability needed for the test. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service under Part A. If the inpatient provider is paid under a prospective payment system (e.g., DRG or RUG) the transportation is considered to be paid within the PPS rate. Because the service is covered and paid under Part A, the service cannot be paid as an ambulance service under Part B.

Prior to the implementation of the fee schedule, some items and services provided as part of the transport were separately reimbursable. Under the ambulance fee schedule, effective for all ambulance claims with dates of service on or after April 1, 2002, oxygen and other items and services provided as part of the transport are included in the base payment rate and are separately payable only for those suppliers who billed for these services prior to the implementation of the fee schedule.

Participating hospitals, CAHs, and SNFs may furnish ambulance services to Part B beneficiaries who are entitled to Part A. The intermediary is responsible for processing claims for these services. These are paid under the ambulance fee schedule, except effective December 21, 2000, ambulance services for CAHs are paid on a reasonable cost basis if:

- The services are furnished by an entity that is owned and operated by a CAH, and
- The CAH or entity is the only provider or supplier of ambulance services located within a 35-mile drive of such CAH.

The carrier is responsible for processing claims from all ambulance service suppliers other than hospitals, critical access hospitals and SNFs.

Beginning February 24, 1999, claims for end stage renal disease (ESRD) patients with a destination of nonhospital-based dialysis facility, origin and destination modifier "J", are covered.

Where the ambulance supplier bills the intermediary, the intermediary is responsible for determining whether the crew and ambulance requirements are met. In cases where all or part of the ambulance services are billed to the carrier, the carrier has this responsibility, and the intermediary must contact the carrier to ascertain whether it has already determined if the crew and ambulance requirements are met. In such a situation, the intermediary should accept the carrier's determination without pursuing its own investigation.

The ambulance fee schedule is effective for claims with dates of service on or after April 1, 2002. The payment amounts during the next four years will be a blended payment amount: part ambulance fee schedule, and part reasonable charge reimbursement (reasonable cost for intermediary). The percentages for the blended rate during the transition period are as follows:

Transition Year	**Reasonable Charge/Cost Percent**	**Fee Schedule Percent**
Year One (4/1/2002-12/2002)	80	20
Year Two (CY 2003)	60	40
Year Three (CY 2004)	40	60
Year Four (CY 2005)	20	80
Year Five (CY 2006)	0	100

In order to ensure that providers/suppliers receive the amounts reimbursable under each of these payment methods, CMS will issue a yearly fee schedule and post it on the CMS Web site. In addition, carriers will supply the reasonable charge amounts through the disclosure process.

A - Billing Methods

Ambulance suppliers are paid based on one of four billing methods:

Method	**Payment**
1	Suppliers are paid at an all-inclusive base rate reflecting all services, supplies, and mileage.
2	Suppliers are paid at a base rate to include supplies with a separate charge for mileage.
3	Suppliers are paid at a base rate to include mileage and services but separate charges for supplies.
4	Suppliers are paid at a base rate with separate charges for supplies and mileage.

Suppliers were converted to a single billing method prior to the implementation of the fee schedule on April 1, 2002. Carriers converted suppliers using multiple billing methods to one of their current billing methods which the claims processing system supports. In the absence of an election, carriers converted the suppliers using multiple billing methods to billing Method 2.

Providers that bill intermediaries other than CAHs paid reasonable, are paid only under Method 2.

B - Carrier Assignment

1 - Assignment of claims (specialty 59) for dates of service prior to April 1, 2002:

Carriers process all covered ambulance claims with dates of service prior to April 1, 2002, as either assigned or unassigned depending on the submission.

2 - Mandatory assignment claims (specialty 59) for dates of service furnished on or after April 1, 2002:

Carriers process all ambulance claims with dates of service on or after April 1, 2002, as assigned. Mandatory assignment for ambulance services, in effect with the implementation of the ambulance fee schedule on April 1, 2002, applies to ambulance providers/suppliers under managed care as well as under fee-for-service. Per 42 CFR 422.214, any provider or supplier without a contract establishing payment amounts for services provided to a beneficiary enrolled in a Medicare + Choice (M+C) coordinated care plan or M+C private fee-for-service plan must accept, as payment in full, the amounts that they could collect if the beneficiary were enrolled in original Medicare. The provider or supplier can collect from the M+C plan enrollee the cost-sharing amount required under the M+C plan, and collect the remainder from the M+C organization.

Carriers split an unassigned ambulance claim with dates of service prior to April 1, 2002, that also contains ambulance services on or after April 1, 2002.

If claims are submitted after April 1, 2002 as unassigned, carriers must convert them to assigned and process them as such. Carriers should use Remittance Advice Remark Code N71 that reads: "Your unassigned claim for a drug or biological, clinical diagnostic laboratory services, or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims."

Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, a representative payee, relative, friend, representative of the institution providing care, or a government agency providing assistance may sign on his/her behalf. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his or her representative, at the time of transport, it may obtain this

signature any time prior to submitting the claim to Medicare for payment. (Per 42 CFR 424.44, there is a 15 to 27 month period for filing a Medicare claim.)

If the beneficiary/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, then the ambulance provider/supplier may not bill Medicare, but may bill the beneficiary (or his or her estate) for the full charge of the ambulance items and services furnished. If, after seeing this bill, the beneficiary/representative decides to have Medicare pay for these items and services, then a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

10.1 - Definitions

(Rev.)

PM AB-02-130

The following are definitions and applications of items used throughout the ambulance chapter. Refer to the Medicare Benefit Policy Manual, Chapter 10, "Ambulance," for definitions of the levels of service.

Adjusted Base Rate

Adjusted base rate is the payment made to a provider/supplier for ambulance services exclusive of mileage.

Application: With respect to ground service levels, the adjusted base rate is the payment amount that results from multiplying the conversion factor (CF) by the applicable relative value unit (RVU) and applying the geographic adjustment factor (GAF). With respect to fixed wing and rotary wing services, the adjusted base rate is equal to the national base rate (which, in the case of air ambulance services, is announced as part of the fee schedule (FS) and is not calculated by means of a CF and RVU) adjusted by the provider's/supplier's GAF.

Advanced Life Support (ALS) Assessment

ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the

protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Ambulance Fee Schedule

The mileage rates provided in this section are the base rates that are adjusted by the yearly ambulance inflation factor (AIF). The payment amount under the fee schedule is determined as follows:

For ground ambulance services, the fee schedule amount includes:

1. A money amount that serves as a nationally uniform base rate, called a "conversion factor" (CF), for all ground ambulance services;

2. A relative value unit (RVU) assigned to each type of ground ambulance service;

3. A geographic adjustment factor (GAF) for each ambulance fee schedule area ((geographic practice cost index (GPCI));

4. A nationally uniform loaded mileage rate; and

5. For services furnished in a rural area, an additional amount for mileage.

For air ambulance services, the fee schedule amount includes:

1. A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;

2. A geographic adjustment factor (GAF) for each ambulance fee schedule area (GPCI);

3. A nationally uniform loaded mileage rate for each type of air service; and

4. A rural adjustment to the base rate and mileage for services furnished in a rural area.

Ambulance Inflation Factor (AIF)

The percentage increase in the consumer price index for all urban consumers, for the 12-month period ending June of the previous year, reduced by 1.0 percentage point.

Conversion Factor

The conversion factor (CF) is a money amount used to develop a base rate for each category of ground ambulance service. The CF will be updated as necessary.

Emergency Response

An emergency response is one that, at the time the ambulance supplier is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part

EMT-Intermediate

EMT-Intermediate is an individual who is qualified, in accordance with State and local laws, as an EMT-Basic **and** who is certified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic

EMT-Paramedic possesses the qualifications of the EMT-Intermediate and, in accordance with State and local laws, possesses enhanced skills including the ability to administer additional interventions and medications.

Geographic Adjustment Factor

Geographic adjustment factor (GAF) is a value that is applied to a portion of the unadjusted base rate amount in order to reflect the relative costs of furnishing ambulance services from one area of the country to another.

The GAF for the ambulance fee schedule uses the nonfacility practice expense (PE) of the geographic practice cost index (GPCI) of the Medicare physician fee schedule to adjust payment to account for regional differences.

Goldsmith Modification

Goldsmith modification is the methodology for the identification of rural census tracts that are located within large metropolitan counties of at least 1,225 square miles but are so isolated from the metropolitan core of that county by distance or physical features as to be more rural than urban in character.

Loaded Mileage

Loaded mileage is the number of miles for which the Medicare beneficiary is transported in the ambulance vehicle.

Application: Payment is made for each loaded mile. Air mileage is based on loaded miles flown, as expressed in statute miles. There are three mileage payment rates: (1) for ground and water; (2) for FW; and (3) for rotary wing (RW). For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.

Paramedic Intercept

Refer to the Medicare Benefit Policy Manual, Chapter 10, for a full definition of Paramedic Intercept.

For Paramedic Intercept, an area is a rural area if:

- It is designated as a rural area by any law or regulation of a State;
- It is located outside of a MSA or NECMA; or
- It is located in a rural census tract of a MSA as determined under the most recent Goldsmith modification.

Presently, one carrier uses the Paramedic Intercept benefit and determines rural status.

Point of Pickup (POP)

POP is the location of the beneficiary at the time he or she is placed on board the ambulance.

Application: The ZIP code of the POP must be reported on each claim for ambulance services so that the correct GAF and Rural Adjustment Factor (RAF) may be applied, as appropriate.

Relative Value Units

Relative value units (RVUs) set a numeric value for ambulance services relative to the value of a base level ambulance service. Since there are marked differences in resources necessary to furnish the various levels of ground ambulance services, different levels of payment are appropriate for the various levels of service. The different payment amounts are based on level of service. An RVU expresses the constant multiplier for a particular type of service (including, where appropriate, an emergency response). An RVU of 1.00 is assigned to the BLS of ground service, e.g., BLS has an RVU of 1; higher RVU values are assigned to the other types of ground ambulance services, which require more service than BLS.

Rural Adjustment Factor (RAF)

RAF is an adjustment applied to the payment amount for ambulance services when the POP is in a rural area.

Application: For ground ambulance services:

A 50 percent increase is applied to the ambulance fee schedule mileage rate for each of the first 17 miles;

A 25 percent increase is applied to the ambulance fee schedule mileage rate for mileage between 18 and 50 miles; and

The urban ambulance fee schedule mileage rate applies to every mile over 50 miles for rural mileage.

For rural air ambulance services, a 50 percent increase is applied to the total air ambulance fee schedule amount for air services; that is, the adjustment applies to the sum of the adjusted base rate and ambulance fee schedule rate for all of the loaded air mileage.

Rural Adjustment

Services in a rural area are services that are furnished:

1. In an area outside a Metropolitan Statistical Area (MSA);

2. In New England, outside a New England County Metropolitan Area (NECMA); or,

3. In an area identified as rural using the Goldsmith modification even though the area is within an MSA.

Rural Area

For the purpose of all categories of ground ambulance services except paramedic intercept, a rural area is defined as a U.S. Postal Service (USPS) ZIP Code that is located, in whole or in part, outside of either a Metropolitan Statistical Area (MSA) or a New England County Metropolitan Area (NECMA), or is an area wholly within an MSA or NECMA that has been identified as rural under the "Goldsmith modification." (The Goldsmith modification establishes an operational definition of rural areas within large counties that contain one or more metropolitan areas. The Goldsmith areas are so isolated by distance or physical features that they are more rural than urban in character and lack easy geographic access to health services.)

Unadjusted Base Rate

Unadjusted base rate is the national general payment amount for ambulance services exclusive of mileage without application of the GAF. These are general national numbers that do not relate to an individual provider/supplier until the GAF is applied to them.

Application: The unadjusted base rate is the payment amount that results from multiplying the CF by the RVU without applying the GAF.

10.2 - Payment Amount (Carriers and Intermediaries)

(Rev.)

B3-4115, B3-5116; PM AB-02-131, AB-00-88, AB-00-131, AB-01-165, AB-02-033

The ambulance final rule published on February 27, 2002, establishes a fee schedule for the payment of ambulance services under the Medicare program thereby implementing §1834(l) of the Social Security Act. The ambulance fee schedule is effective for claims with dates of service on or after April 1, 2002. The final rule established a 5-year transition period, during which time payment will be based on a blended amount based in part on the ambulance fee schedule and in part on reasonable cost (for intermediaries) or reasonable charge (for carriers).

The following subsections describe how carriers and intermediaries calculate the payment amount. Sections 10.2.2 and 10.2.3 provide information for payment calculations for claims with dates of service **prior to** April 1, 2002. The other subsections provide information on certain components of the payment amount (e.g., mileage) or specialized payment amounts (e.g., air ambulance).

Payment under the reasonable charge reimbursement methodology:

- Ambulance suppliers are paid under one of four billing methods described in §10.1 above.

- In some areas, there may be two or more ambulance companies billing differently based on the billing method selected, e.g., one may bill on the basis of a base rate plus mileage whereas another may use a rate including mileage.

- Furthermore, one company may have an all-inclusive rate whereas another may bill standard rate plus extra charges based on additional services furnished, such as EKG monitoring.

Payment under the reasonable cost reimbursement methodology:

- The provider is paid reasonable costs for ambulance services. However, costs in excess of the reasonable charge amounts are not considered reasonable costs.

Payment under the fee schedule for ambulance services:

- Includes a base rate payment plus a separate payment for mileage;

- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and

- Precludes a separate payment for items and services furnished under the ambulance benefit, except for those suppliers who billed separately for these items and services prior to the implementation of the fee schedule. Such items and services include but are not limited to oxygen, drugs, extra attendants, and EKG testing - but only when such items and services are both medically necessary and covered by Medicare under the ambulance benefit.

The basic elements of the fee schedule are:

A. Ground Ambulance Services

1. Service Payment Amount

The GAF is one of two factors intended to address regional differences in the cost of furnishing ambulance services. Thus, the geographic areas applicable to the ambulance fee schedule are the same as those used for the physician fee schedule.

The location where the beneficiary was put into the ambulance ("POP") establishes which GPCI applies. For ground ambulance services, the applicable GPCI is multiplied by 70 percent of the base rate. Again, the base rate for each category of ground ambulance services is the CF multiplied by the applicable RVU. The GPCI is not applied to the mileage factor.

2. Mileage Payment Amount

The ambulance fee schedule provides a separate payment amount for mileage. The mileage rate for all types of ground ambulance services, except Paramedic Intercept, is $5 per loaded statute mile in the fee schedule base year (calendar year 2000) and is adjusted each year by the Ambulance Inflation Factor (AIF). Providers and suppliers must report all medically necessary mileage, including the mileage subject to a rural adjustment, in a single line item.

3. Rural Ground Mileage Payment Amount

Payment is adjusted upward for ambulance services that are furnished in rural areas to account for the higher costs per ambulance trip that are typical of rural operations where fewer trips are made in any given period. Refer to the definition of rural adjustment in Definitions, §10.1, of this chapter.

If the POP is a rural ZIP code, the following calculations should be used to determine the rural adjustment portion of the payment allowance. The rural adjustment for ground mileage is 1.5 times the urban mileage allowance for the first 17 loaded miles, and 1.25 times the urban mileage allowance for any loaded miles between 18 and 50, inclusive. For all ground miles greater than 50, the urban mileage rate per mile is paid.

The POP, as identified by ZIP code, establishes whether a rural adjustment applies to a particular service. Each leg of a multi-leg transport is separately

evaluated for a rural adjustment application. Thus, for the second (or any subsequent) leg of a transport, the ZIP code of the POP establishes whether a rural adjustment applies to such second (or subsequent) transport.

Although a transport with a POP located in a rural area is subject to a rural adjustment for mileage, Medicare still pays the lesser of the billed charge or the applicable fee schedule amount for mileage. Thus, when rural mileage is involved, the contractor compares the fee schedule rural mileage payment rate blended with the reasonable cost/charge mileage amount to the provider's/supplier's actual charge for mileage and pays the lesser amount.

The CMS furnishes the files that will electronically determine whether a particular ZIP code is rural or urban.

B. Air Ambulance Services

1. Service Payment Amount

Each type of air ambulance service has a base rate. There is no conversion factor (CF) applicable to air ambulance services. Also, air ambulance services have no RVUs. The GAF, as described above for ground ambulance services, is applied in the same manner to air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50 percent of each of the base rates (fixed and rotary wing).

2. Mileage

The fee schedule for air ambulance services provides a separate payment for the mileage rate for fixed wing ambulance services. The mileage rate for rotary wing ambulance services is published by CMS on an annual basis. Mileage on air ambulance services (fixed or rotary wing), the rural adjustment is an increase of 50 percent.

3. Adjustment for Services Furnished in Rural Areas

Payment is adjusted upward for air ambulance services that are furnished in rural areas. For air ambulance services (fixed or rotary wing), the rural adjustment is an increase of 50 percent to the unadjusted fee schedule amount, i.e., 1.5 times both the applicable air ambulance service base rate and the mileage amount.

The ZIP code of the POP determines whether a rural adjustment applies. See the definition for rural adjustment in §10.1.

10.2.1 - Payment Amount During Transition

(Rev.)

AB-01-185, AB-01-165, AB-02-117

The ambulance fee schedule is subject to a 5-year transition period as follows:

Year	**Fee Schedule Percentage**	**Reasonable Cost/Charge Percentage**
Year 1 (4/1/02 - 12/31/02)	20%	80%
Year 2 (CY 2003)	40%	60%
Year 3 (CY 2004)	60%	40%
Year 4 (CY 2005)	80%	20%
Year 5 (CY 2006 and thereafter)	100%	0%

Calculating the Blended Rate During the Transition

Before the implementation of the fee schedule, the payment of ambulance services followed one of two methodologies.

- Suppliers (carrier claims) were paid based on a reasonable charge methodology; or

- Providers (intermediary claims) were paid based on the provider's interim rate (which is a percentage based on the provider's historical cost-to-charge ratio multiplied by the submitted charge) and then cost-settled at the end of the provider's fiscal year.

For services furnished during the transition period, payment of ambulance services is a blended rate that consists of both a fee schedule component and a provider or supplier's current payment methodology as follows:

- For suppliers, the blended rate includes both a portion of the reasonable charge and the fee schedule amount. For the purpose of implementing the transition to the fee schedule, for each supplier carriers use the reasonable charge for 2000 (e.g., the lowest of the customary charge, the prevailing charge, or the inflation indexed charge (IIC) previously determined for 2000) adjusted for each year of the transition period by the ambulance inflation factor as published by CMS.

- Suppliers using Method 3 or 4 may bill HCPCS codes A0382, A0384 and A0392 - A0999, J-codes, and codes for EKG testing for dates of service during the transition period. Methods 3 and 4 will be subject to the phase-in. Carriers must apply the appropriate transition year percentage to the reasonable charge amount for these codes. (Because separately billable items are not recognized under the fee schedule, there is no blended amount for these codes.) Payment is denied for such codes if billed by a Method 1 biller or Method 2 biller. Carriers can not change established supplier payment methods.

- Intermediaries must determine both the reasonable cost for a unit of ambulance service furnished by a provider, and the fee schedule amount that would be payable for the service. The intermediaries then must apply the appropriate blend percentage to each such amount to derive a blended-rate payment amount applicable to the service. The cost report is used for the calculation. The reasonable cost part of the rate is provider specific.

Ambulance companies may also charge for a night differential, disposable supplies, or travel to a difficult or hard to reach location. The total reasonable charge portion of the payment for an ambulance service may reflect one or more of these factors.

A. Special Carrier Instructions for Transition

For claims with dates of service furnished on or after April 1, 2002, carriers pay the lower of the submitted charge or the blended amount determined under the fee schedule transition. For example, for services furnished between April 1, 2002 and December 31, 2002, the blended amount consisted of 80 percent of the reasonable charge plus 20 percent of the ambulance fee schedule amount.

For implementing the transition to the fee schedule, the reasonable charge for each supplier is the reasonable charge for 2000 (e.g., the lowest of the customary charge, the prevailing charge, or the IIC previously determined for 2000) adjusted by the ambulance inflation factor, as published by CMS, for each subsequent year ending with the last year of the transition period.

Carriers must send a reasonable charge file to the Railroad Retirement Board, the appropriate State Medicaid Agencies, the United Mine Workers, and the Indian Health Service. A reasonable charge update should not be performed for referral to these entities. Instead, the carriers send the same reasonable charge data that was developed during the based year (CY2000) and updated by the AIF for the current year.

Claims are processed using the new HCPCS codes created for the ambulance fee schedule. Carriers were required to crosswalk HCPCS codes to determine the reasonable charge amount attributable to the new HCPCS codes. If a carrier currently used local codes, it was required to establish its own supplemental crosswalk with respect to any such local codes. If practical, carriers converted all suppliers to one billing method. If a supplier bills a new HCPCS code for which there is insufficient actual charge data,

carriers follow the instructions for gap filling in the Medicare Claims Processing Manual, Chapter 23, "Fee Schedule Administration and Coding Requirements."

For each ambulance claim, the carrier or intermediary accesses the ZIP code file provided by CMS to determine the appropriate locality code for the fee schedule. Only the locality code from the fee schedule should be entered into the claim record in the appropriate field. The CWF edit for locality code is bypassed for specialty 59 during the transition period. CWF locality codes are required only for items and services payable by reasonable charge.

To establish a supplier specific reasonable charge for the new HCPCS mileage code A0425, carriers develop an average, e.g., a simple average, not a weighted average, from the supplier specific reasonable charges of the old mileage codes A0380 and A0390. The average amount is used as the reasonable charge for 2001 and updated by the Ambulance Inflation Factor.

Methods 3 and 4 HCPCS codes for items and supplies, J-codes, and codes for EKG testing, are valid until the transition is completed. Payment for such Method 3 and 4 HCPCS codes (which is available only to a current Method 3 or Method 4 biller at the time the fee schedule is implemented) is based on the reasonable charge for such items and services (80 percent beginning April 1, 2002). The reasonable charge for these HCPCS codes for each year of the transition is determined in the same manner as described above for ambulance services.

B. Carrier Determination of Fee Schedule Amounts

- If an urban ZIP code is reported with a ground or air HCPCS code, the carriers determine the amount for the service by using the fee schedule amount for the urban base rate. To determine the amount for mileage, multiply the number of reported miles by the urban mileage rate.

- If a rural ZIP code is reported with a ground HCPCS code, the carrier determines the amount for the service by using the fee schedule amount for the urban base rate. To determine the amount for mileage, carriers must use the following formula:

    - For rural miles 1-17, the rate is 1.5 times the urban ground mileage rate per mile. Multiply 1.5 times the urban mileage rate amount on the fee schedule to derive the appropriate payment per mile;

    - For rural miles 18-50, the rate is 1.25 times the urban ground mileage rate per mile. Multiply 1.25 times the urban mileage rate amount on the fee schedule to derive the appropriate payment per mile; and

    - For all ground miles greater than 50, pay the urban mileage rate per mile.

- If a rural ZIP code is reported with an air HCPCS code, the carrier determines the amount for the service by using the fee schedule amount for rural base rate. To

determine the amount allowable for the mileage, multiply the number of loaded miles by the rural mileage rate.

C. Summary of Claims Adjudication Under the Transition

The following summarizes the claims adjudication process for ambulance claims during the fee schedule transition period. These steps represent a conceptual model only. They are not programming instructions.

- The supplier's 2002 reasonable charge for each HCPCS code for each reasonable charge locality is established by adjusting the reasonable charge for 2000 by the 2001 and 2002 ambulance inflation factors. Refer to the chart in the beginning of this section for additional years;

- For each ambulance claim, the carrier accesses the ZIP code file provided by CMS to determine both the appropriate locality code for the fee schedule and the rural adjustment indicator, if any;

- For each mileage line item with an urban ZIP code, the carrier uses the mileage HCPCS code and the number of reported miles and multiplies the number of miles by the urban mileage rate specified in the fee schedule file;

- If the HCPCS code is a ground service with a rural ZIP code, pay in accordance with related procedures outlined elsewhere in this chapter;

- If the HCPCS code is an air service with a rural ZIP code, then the carrier will use the rural service amount and the rural mileage amount;

- The carrier must then add the percent of the fee schedule amount for the service and the percent of the reasonable charge amount for the given transition year of the old HCPCS code that crosswalks to the new HCPCS code for the service. The resulting sum is the blended amount for the service. The carrier then compares the blended amount with the corresponding submitted charge and carries forward the lower of the two amounts as the allowed charge;

- The carrier must then add the percent of the fee schedule amount for the given transition year for the mileage and the percent of the reasonable charge of the old HCPCS code that crosswalks to the new HCPCS code for the mileage (if any). The resulting sum is the blended amount for the mileage. The carrier then compares the blended amount with the corresponding submitted charge and carries forward the lower of the two amounts as the allowed charge;

- If the supplier is a Method 3 or Method 4 biller, and if the supplier submits a charge for a separately billable item or service, the carrier determines the reasonable charge for a particular year (e.g., 40% for 2003) for the reported HCPCS code for the item. The carrier then compares that amount (because there is no blended amount for separately billable line items) to the submitted charge for that HCPCS code and carries forward the lower of the two amounts;

- The carrier then sums the line item amounts for the service, for the mileage, and, when applicable, for separately billable line items; subtracts the deductible when appropriate, subtracts the coinsurance, and pays the resulting amount.

NOTE: Subsequent transition years are calculated according to the percentages described in the beginning of this section, §10.2.1.

10.2.1.1 - Special Payment Rules for Intermediaries During Fee Schedule Transition

(Rev.)

PMs AB-00-88, AB-01-165, AB-02-117, AB-01-185

For providers (hospitals, SNFs and any CAHs for which cost reimbursement is not available) that file cost reports on other than a calendar year basis for cost reporting periods beginning after April 1, 2002, the cost report must be split into two different periods in which two different blended rates apply.

Effective for services furnished from April 1, 2002, to December 30, 2002, the blended amount for provider claims is equal to the sum of 80 percent of the current ambulance payment system amount (reasonable cost) and 20 percent of the ambulance fee schedule amount. The provider payment amount before consideration of deductible or coinsurance is the lower of (the blended amount) or (the interim rate times the billed charges).

During Year 2, the fee schedule amount is 40 percent of the blended amount and the provider's reasonable cost, or the supplier's reasonable charge will comprise the remaining 60 percent. During Year 3, the fee schedule amount is 60 percent of the blended amount and the provider's reasonable cost, or the supplier's reasonable charge will comprise the remaining 40 percent. During Year 4, the fee schedule amount is 80 percent of the blended amount and the provider's reasonable cost, or the supplier's reasonable charge will comprise the remaining 20 percent. Beginning with Year 5, e.g., for services and supplies furnished and mileage incurred, beginning January 1, 2006, and each year thereafter, the full fee schedule is entirely the Medicare allowed amount, and no portion of the provider's reasonable cost or the supplier's reasonable cost is included.

A - Payment Calculation During Transition

For claims with dates of service on or after April 1, 2002, and continuing through the transition, intermediaries pay providers a blended rate, which equals the sum of a percentage of the providers' current payment system (reasonable cost) and a percentage of the fee schedule, applicable to a particular year.

For claims with dates of service from April 1, 2002, through December 31, 2002, intermediaries must determine a cost per ambulance trip based on the provider's ambulance costs and number of ambulance trips. A blended amount is determined, calculated based on the sum of the following:

- The provider's calculated cost per trip multiplied by 80 percent (transition percentage). This payment calculation is the sum of the base rate and mileage payment. These amounts are cost settled at the end of the providers fiscal year and limited by the statutory inflation factor applied to 80 percent of the providers cost per ambulance trip limit applicable to a particular service; and

- Twenty percent of the fee schedule amount that is a combination of the base rate and mileage payment. (Refer to subsection C below).

For calendar years after 2002, use the percentages described above (e.g., 40, 60, 80 and 100 where applicable for the year). However, cost-based amounts will be based on the initial cost established and updated using the inflation factor provided in the law. (CMS will provide the update factor as needed.)

NOTE: Rural mileage requires additional calculations, which are described in §20.1.6.B.

Deduct any applicable Medicare Part B deductible and coinsurance.

B - New Providers

New providers do not have a cost per trip from the prior year. Therefore, there is no cost per trip inflation limit applied to new providers in their first year of furnishing ambulance services.

C - Calculation of Fee Schedule Payment During Transition

Intermediaries pay providers based on the geographic location where the beneficiary is placed into the ambulance (POP). Use the 5-digit ZIP code of the POP to identify this location. The provider must report this information in field locator 39-41 (Value Code) using A0 (zero) and the related 5-digit ZIP code.

Intermediaries electronically crosswalk the ZIP code to the appropriate carrier locality using the ZIP code mapping file designating rural areas, which CMS supplies. Intermediaries consider all ZIP codes on the list urban unless identified as rural (indicated with the letter "R" after the locality.) The intermediary then uses the fee for the corresponding carrier locality for payment to the provider.

For claims with dates of service after April 1, 2002, intermediaries pay 20 percent of the base rate and mileage rate of the fee schedule amounts as follows:

- If an urban ZIP code is reported in conjunction with a ground or air HCPCS code, pay the urban base rate specific to the HCPCS code reported for that location. In addition, pay for the number of miles reported multiplied by the urban mileage amount specific to the HCPCS code reported.

- If a rural ZIP code is reported for a ground HCPCS code, pay the urban base rate for that location, the rural mileage amount for each of the first 17 loaded miles, and the urban mileage payment rate for every mile over 17 miles.

- If a rural ZIP code is reported in conjunction with an air HCPCS code, pay the rural base rate and rural mileage multiplied by the number of miles reported.

For subsequent years, intermediaries adjust the percentages of the fee schedule amounts as previously described.

EXAMPLES

The numbers in the following examples are **for illustrative purposes only**.

EXAMPLE 1: In this example, $200 is the provider's billed charges, 90 percent is the provider's interim rate, and $150 is the full amount (the sum of the base rate and mileage rate) from the fee schedule. Part B deductible has been met.

$200	Provider's billed charges
X 90%	Provider's interim rate
$180	
x 80%	2002 transition percentage
$144	Transition amount
+ 30	20% of the Ambulance Fee Schedule amount of $150
$174	
- 38	Applicable 20% coinsurance*
$136	Reimbursement to provider

*To determine the applicable coinsurance amount:

$200	Provider's billed charge
x 80ff	2002 transition percentage
$160	
+ 30	20% of the Ambulance Fee Schedule amount of $150
$190	
x 20%	
$ 38	Beneficiary coinsurance amount

EXAMPLE 2: All charges and rates are the same as in example 1. However, the $100 Part B deductible has not been met.

$200	Providers billed charge
x 90%	Providers interim rate
$180	
x 80%	2002 transition percentage
$144	Transition amount
+ 30	20% of the Ambulance Fee Schedule Amount of $150
$174	
- 100	Part B deductible to be met
$74	
- 18	Applicable 20% coinsurance*
$56	Reimbursement to provider

*To determine the applicable coinsurance amount:

$200	Providers billed charge
x 80%	2002 transition percentage
$160	
+ 30	20% of the Ambulance Fee Schedule Amount of $150
$190	
- 100	Part B deductible to be met
$ 90	
x 20%	
$ 18	Beneficiary coinsurance amount

10.2.2 - Reasonable Charge

(Rev.)

B3-5116.1, PMs AB-01-22, AB-00-87, AB-01-185

NOTE: Procedures in §10.2.2 are being phased out, but the rules apply during the transition.

Carriers must develop two separate base rates for the basic ambulance and the other for the ALS ambulance.

The reasonable charge must be established to include the components of each of the methods identified in §10.2 above (e.g., reasonable charge for Method 1 includes services, supplies, and mileage).

A - Both Basic and ALS Ambulance Services Available (Applies to Claims With Dates of Service Prior to 4/1/02)

When there are both basic and ALS ambulances furnishing services in a locality, carriers establish separate customary and prevailing base rate screens for each type of ambulance in accordance with the regular reasonable charge methodology. The ALS reasonable charge may be used, except as indicated below, as a basis for payment whenever an ALS ambulance is used. However, there may be instances when a supplier establishes a pattern of uneconomical care such as repeated use of ALS ambulances in situations in which it should have been known that a less expensive basic ambulance was available and that its use would have been medically appropriate. If carriers become aware of such a pattern, payment for that ambulance supplier's service is based on the customary and prevailing base rate for basic ambulance services. The reasonable ALS rate is then allowed only if the need for the ALS ambulance is specifically documented on the claim.

B - Inconsistent Billing for ALS Ambulance Services (Applies to Claims with Dates of Service Prior to April 1, 2002)

When the billing practices of suppliers of ALS ambulance services are not consistent, e.g., some suppliers bill an all-inclusive base rate while others bill a base rate plus separate charges for covered specialized ALS services, carriers develop and use different base rate prevailing charges for each type of billing arrangement:

1. The carrier uses only the all-inclusive charges for covered Part B services in calculating the customary and prevailing base rate screens for ALS ambulance suppliers who bill all-inclusive charges; and

2. The carrier merges the data on base rate charges for ALS ambulance suppliers not included in paragraph l above with similar data from basic ambulance services to establish a base rate prevailing charge screen that will be applied to claims for both types of ambulance services. Separate additional charges may be allowed for a specialized ALS service as indicated in §20.3 below, if the service is covered

under Part B, so long as the total reasonable charge allowed for the ALS service generally does not exceed the all-inclusive prevailing base rate for ALS ambulance services (where there is one).

If there are only ALS ambulance suppliers with separate additional charges for specific covered services in the locality (e.g., no basic ambulances), the ALS ambulance suppliers' charges would be used to establish the reasonable charge screens.

C - Update Charges

Update factors described in this section apply to the reasonable charge portion of the ambulance payment. During the fee schedule transition, the examples below describe how the updates are applied to the reasonable charge portion of the payment.

In general, for 2001, the reasonable charge is the reasonable charge limit for 2000 (e.g., the lowest of the 2000 prevailing charge, customary charge, or IIC) multiplied by the reasonable charge ambulance inflation factor for 2001. For 2002, the reasonable charge is the amount determined for 2001 multiplied by the reasonable charge ambulance inflation factor for 2002. For 2003, the reasonable charge is the amount determined for 2002 multiplied by the reasonable charge ambulance inflation factor for 2003.

EXAMPLE A: 1/01/01 - 6/30/01

For services furnished during the period January 1, 2001, through June 30, 2001, the 2001 IIC update factor for ambulance services (also known as the ambulance inflation factor) paid under reasonable charges **remains at 2.7 percent**. Therefore, the carriers calculate the 2001 reasonable charge screen amount for ambulance services furnished during this period by increasing the 2000 reasonable charge screen amount by 2.7 percent.

EXAMPLE B: 7/1/01 - 12/31/01

For services furnished during the period July 1, 2001, through December 31, 2001, the reasonable charge update factor applicable to ambulance services is **4.7 percent**. Therefore, carriers calculate the 2001 reasonable charge screen amount for ambulance services furnished during this period by increasing the 2000 reasonable charge screen amount by 4.7 percent.

(**NOTE:** This 4.7 percent increase is applied to the 2000 reasonable charge limit amount, **not** to the 2001 reasonable charge limit amount.)

10.2.2.1 - Effect of Separate Charges for Covered Specialized Advanced Life Support (ALS) Services on Reasonable Charges for Ambulance Services

(Rev.)

B3-5116.2

This section applies to claims with dates of service prior to April 1, 2002, and the reasonable charge portion of the payment during the fee schedule transition.

Where separate charges are billed for the specific covered ALS services, reasonable charge screens for each such service should be constructed using the regular reasonable charge methodology. When a claim is filed for any one or a combination of such covered services, the maximum allowable charge for the total ambulance service must take into consideration the supplier's base rate reasonable charge (see §10.2.2) plus the reasonable charge for the specific specialized service(s).

For example, if an ambulance supplier submits a separate additional charge for covered EKG monitoring, the maximum reasonable charge for the ambulance service would be the lowest of:

1. The supplier's actual base rate and specialized service charge;

2. The supplier's customary base rate and customary specialized service charge; or

3. The prevailing base rate charge in the locality for basic ambulance services and the prevailing charge for the specialized service.

An increase in the reasonable charge for the ambulance service because of separately itemized specialized services should be allowed **only** where such a service is determined to be reasonable and necessary.

10.2.3 - Reasonable Cost (Intermediaries) Prior to April 1, 2002

(Rev.)

A3-3660.1, SNF-539, HHA-477, HO 433, PMs AB-00-118, AB-00-131, A-01-48

Instructions contained in this section are applicable for claims paid under reasonable cost with dates of service prior to April 1, 2002.

The provider must furnish the following data in accordance with intermediary instructions:

- A detailed statement of the condition necessitating the ambulance service;

- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- POP (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services. Explain.

Section 4531(a)(1) of the Balanced Budget Act (BBA) of 1997 provides that in determining the reasonable cost of ambulance services furnished by a provider of services, the Secretary shall not recognize the cost per trip in excess of the prior year's reasonable cost per trip updated by an inflation factor equal to the consumer price index for all urban consumers (CPI-U) minus one percent. This determination is effective with services furnished during Federal Fiscal Year (FFY) 1998 (between October 1, 1997 and September 30, 1998), FFY 1999, and as much of FFY 2000 as precedes January 1, 2000.

Providers are to bill for Part B ambulance services using the billing method of base rate including supplies, with mileage billed separately.

Refer to the instructions in §20.2.2.1 for billing procedures for the above provisions and a list of bill types paid on a reasonable charge basis.

10.2.4 - Payment for Mileage Charges

(Rev.)

B3-5116.3, PM AB-00-131

In service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an additional payment based on customary and prevailing mileage charges may be allowed. Charges for mileage must be based on loaded mileage only, e.g., from the pickup of a patient to his/her arrival at destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes his basic

charge for ambulance services and his rate for loaded mileage. Suppliers should be notified that separate charges for unloaded mileage will be denied.

Instructions on billing mileage are found in §30.1.

10.2.5 - Geographic Adjustment Factor (GAF)

(Rev.)

AB-02-130, AB-00-88, AB-00-131, AB-01-165, AB-02-33

Refer to §10.1 for a definition of GAP.

For ground ambulance services, the PE portion of the GPCI is applied to 70 percent of the unadjusted base rate. For air ambulance services, the PE portion of the GPCI is applied to 50 percent of the unadjusted base rate.

10.2.6 - Relative Value Unit (RVU)

(Rev.)

AB-02-130, AB-00-88, AB-00-131, AB-01-165, AB-02-33

Refer to §10.1 for a definition of Relative Value Units.

The RVUs for the ambulance fee schedule are as follows:

Service Level	**RVUs**
BLS	1.00
BLS - Emergency	1.60
ALS1	1.20
ALS1 - Emergency	1.90
ALS2	2.75
SCT (Specialty Care Transport)	3.25
PI (Paramedic Intercept)	1.75

RVUs are not applicable to FW and RW services.

10.2.7 - ZIP Code Determines Fee Schedule Amounts

(Rev.)

PMs AB-00-88, AB-01-165, Training Book-CH 3, AB-02-131

The POP, as reported by the 5-digit ZIP code, determines the basis for payment under the fee schedule. Thus, the ZIP code of the POP determines both the applicable GPCI and whether a rural adjustment applies. Accordingly, the ZIP code must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment.

A - No ZIP Code

In areas without an apparent ZIP code, it is the provider's/supplier's responsibility to confirm that the POP does not have a ZIP code that has been assigned by the USPS. If the provider/supplier has made a good-faith effort to confirm that no ZIP code exists, it may use the ZIP code nearest to the POP.

Providers and suppliers should document their confirmation with the USPS, or other authoritative source, that the POP does not have an assigned ZIP code and annotate the claim to indicate that a surrogate ZIP code has been used (e.g., "Surrogate ZIP code; POP in No-ZIP"). Providers and suppliers should maintain this documentation and provide it to their intermediary or carrier upon request.

If the ZIP code entered on the claim is not in the CMS-supplied ZIP Code File, contractors must manually verify the ZIP code to identify a potential coding error on the claim or a new ZIP code established by the U.S. Postal Service (USPS). ZIP code information may be found at the USPS Web site at www.usps.com, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim may be processed. All such ZIP codes are to be considered urban ZIP codes until CMS determines that the code should be designated as rural. If this process does not validate the ZIP code, the claim must be rejected as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

Contractors must request additional documentation from providers/suppliers when a claim submitted using a surrogate ZIP code does not contain sufficient information to determine that the ZIP code does not exist for the POP. They must investigate and report any claims submitted with an inappropriate and/or falsified surrogate ZIP code.

B - New ZIP Codes

New ZIP codes are considered urban until CMS determines that the ZIP code is located in a rural area. Thus, until a ZIP code is added to the Medicare ZIP code file with a rural designation, it will be considered an urban ZIP code. However, despite the default designation of new ZIP codes as urban, intermediaries and carriers have discretion to determine that a new ZIP code is rural until designated otherwise based on the criteria established for defining an area as rural, as defined in the Ambulance Fee Schedule Final

Rule (67 FR 9100). If the contractor designates a new ZIP code as rural, and CMS later changes the designation to urban, then the contractor, as well as any provider or supplier paid for mileage or for air services with a rural adjustment, will be held harmless for this adjustment.

Providers and suppliers should annotate claims using a new ZIP code with a remark to that effect. Providers and suppliers should maintain documentation of the new ZIP code and provide it to their intermediary or carrier upon request.

If the provider or supplier believes that a new ZIP code that the contractor has designated as urban should be designated as rural (under the standard established by the Medicare fee schedule regulation), it may request an adjustment from the intermediary or appeal the determination with the carrier, as applicable, in accordance with standard procedures.

When processing a claim with a POP ZIP code that is not on the Medicare ZIP code file, contractors must search the USPS Web site at www.usps.com, other governmental Web sites, and commercial Web sites, to validate the new ZIP code. (The Census Bureau Web site located at tier2.census.gov/ctsl/ctsl.htm contains a list of valid ZIP codes.) If the ZIP code cannot be validated using the USPS Web site or other authoritative source such as the Census Bureau Web site, reject the claim as unprocessable.

C - Inaccurate ZIP Codes

If providers and suppliers knowingly and willfully report a surrogate ZIP code because they do not know the proper ZIP code, they may be engaging in abusive and/or potentially fraudulent billing. Furthermore, a provider or supplier that specifies a surrogate rural ZIP code on a claim when not appropriate to do so for the purpose of receiving a higher payment than would have been paid otherwise, may be committing abuse and/or potential fraud.

D - Claims Outside of the U.S.

Medicare only pays for emergency transports. For coverage and limitations for ambulance services furnished in connection with foreign inpatient hospital services, refer to the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §10.1.3, and the Code of Federal Regulations at 42 CFR 411.9.

The following policy applies to claims outside of the U.S.:

- Ground transports with pickup and drop off points within Canada or Mexico will be paid at the fee associated with the U.S. ZIP code that is closest to the POP;
- For water transport from the territorial waters of the U.S., the fee associated with the U.S. port of entry ZIP code will be paid;
- Ground transports with pickup within Canada or Mexico to the U.S. will be paid at the fee associated with the U.S. ZIP code at the point of entry; and

- Fees associated with the U.S. border port of entry ZIP codes will be paid for air transport from areas outside the U.S. to the U.S. for covered claims.

As discussed more fully below, CMS will provide intermediaries and carriers with a file of ZIP codes that will map to the appropriate geographic location with a rural designation identified with the letter "R", if appropriate.

10.2.8 - Payment Under SNF Consolidated Billing

(Rev.)

SNF-516.2, SNF QA Day4

The following ambulance transportation and related ambulance services for residents in a Part A stay are not included in the PPS rate. They may be billed as Part B services by the supplier in only the following situations.

- The ambulance trip is to the SNF for admission (the second character (destination) of any ambulance HCPCS code modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21x admission date.)

- The ambulance trip is from the SNF to home (the first character (origin) of any HCPCS code ambulance modifier is N (SNF)), and date of ambulance service is the same date as the SNF through date, and the SNF patient status (FL 22) is other than 30.)

- The ambulance trip is to a hospital based or nonhospital based ESRD facility (either one of any HCPCS code ambulance modifier codes is G (Hospital based dialysis facility) or J (Nonhospital based dialysis facility).

Ambulance associated with the following inpatient hospital service exclusions payment is under the ambulance fee schedule:

- Cardiac catheterization;

- Computerized axial tomography (CT) scans;

- Magnetic resonance imaging (MRIs);

- Ambulatory surgery involving the use of an operating room;

- Emergency services;

- Angiography;

- Lymphatic and Venous Procedures; and

- Radiology therapy.

Finally, ambulance transportation for removal, replacement, and insertion of PEG tubes is an excluded service under consolidated billing for Part A and is not considered a SNF service. Therefore, that ambulance is also excluded from SNF consolidated billing, and the service would be billed to the carrier under Part B.

10.3 - Joint BLS/ALS Responses

(Rev.)

PMs AB-02-131, AB-03-007

A - BLS/ALS Joint Responses

In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, Paramedic Intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their intermediary or carrier upon request. Contractors must refer any issues that cannot be resolved to the regional office.

There must be a written agreement in place between the BLS supplier that furnishes the transport and the ALS entity that furnishes the ALS service.

Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

B - Ground to Air Ambulance Transports

For situations in which a beneficiary is transported by ground ambulance to or from an air ambulance, the ground and air ambulance providers/suppliers providing the transports must bill Medicare independently. Under these circumstances, Medicare pays each provider/supplier individually for its respective services and mileage. Each provider/supplier must submit a claim for its respective services/mileage to the intermediary/carrier that has jurisdiction for the locality in which its ambulance is based.

For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. Thus, for the second (or any subsequent) leg of a transport, the POP establishes the applicable GPCI for that portion of the ambulance transport.

10.4 - Special Situations

10.4.1 - Multiple Patient Transport

(Rev.)

PMs B-02-060, AB-01-185, A-02-108; CMS Q&As, B3-5215.2

The payment policy for pricing a single ambulance vehicle transport of a Medicare beneficiary where more than one patient is onboard the ambulance follows. It applies to supplier and provider claims:

1. When more than one patient is transported in an ambulance, the Medicare allowed charge for each beneficiary is a percentage of the allowed charge for a single beneficiary transport. (The allowed charge for a single beneficiary transport is the lower of (a) the submitted charge or (b) the fee schedule amount for the service, which during the fee schedule transition period is a blended amount.) The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.

   NOTE: This policy applies to both ground and air transports. For purposes of this section, the term "ground transport" includes transports by water ambulance.

2. If two patients are transported at the same time in one ambulance to the same destination, the adjusted payment allowance for each Medicare beneficiary is equal to 75 percent of the single-patient allowed amount applicable to the level of service furnished a beneficiary plus 50 percent of the total mileage payment allowance for the entire trip.

3. If three or more patients are transported at the same time in one ambulance to the same destination, the adjusted payment for each Medicare beneficiary is equal to 60 percent of the single-patient allowed amount applicable to the level of service furnished that beneficiary plus a proportional mileage allowed amount, e.g., the total mileage allowed amount divided by the number of all the patients onboard.

   The fact that the level of medically necessary service among the patients may be different is not relevant to this payment policy. The percentage is applied to the allowed amount applicable to the level of service that is medically necessary for each beneficiary.

4. If a multi-patient transport includes multiple destinations, then the Medicare allowed amount for mileage depends upon whether it is for an emergency versus nonemergency ground transport.

   a. For an emergency ground transport, which includes BLS-E, ALS1-E, ALS2, and SCT, the mileage payment shall be based on the number of miles to the nearest appropriate facility for each patient divided by the number of patients on board when the vehicle arrives at the facility. This

formula applies cumulatively for beneficiaries who are the second or third patient to be delivered. Absent evidence to the contrary, carriers should assume that the sequence of deliveries was predicated on the medical needs of each patient.

b. For a nonemergency ground transport, which includes BLS and ALS1, the mileage payment shall be based on the number of miles from the POP to the nearest appropriate facility for each beneficiary divided by the number of beneficiaries on board at the POP. This formula applies cumulatively for beneficiaries for multiple points of pickup. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the POP to the nearest appropriate facility is not covered. Thus, for nonemergency transports, the extra mileage that may be incurred by having multi-destinations shall not be taken into account.

c. For air transports the policy is the same as for emergency ground transports.

5. If a Medicare beneficiary is furnished medically necessary supplies and the supplier bills supplies separately, then the allowed amount of the supplies is not subject to an apportionment for multiple patients. The allowed amount for supplies should be determined in the same manner as if the beneficiary was the only patient onboard the vehicle.

Modifier "GM" is used to identify a multiple transport. Suppliers/providers must submit:

- Documentation to specify the particulars of a multiple transport: The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers for each Medicare beneficiary;

- Charges applicable to the appropriate service rendered to each beneficiary and the total mileage for the trip;

- All associated Medicare claims for that multiple transport within a reasonable number of days of submitting the first claim;

If there is only one Medicare beneficiary in the multiple patient transport, contractors must process the claims using the necessary information from the supplier's documentation.

If more than one Medicare beneficiary is transported in a multiple patient transport, then the contractor must associate all ambulance claims for Medicare beneficiaries for the one transport.

The contractor must process the claims and apply the correct percentages to the allowed amount applicable to the level of service furnished and mileage.

When two patients are transported, for each beneficiary:

- The contractor allows 75 percent of the allowed amount for a single-person transport (excluding separately billable mileage);

- For mileage to a single destination, the contractor allows half of the total mileage;

- For mileage for both emergency ground transports and all air transports to multiple destinations, the allowed amount for the first leg is the amount for the mileage divided by two. The allowed amount for the second leg is the full mileage. Thus, payment on behalf of a beneficiary whose transport is to the first nearest appropriate facility is based on half the mileage amount to that facility; whereas, payment on behalf of the second beneficiary, whose transport was to the next nearest appropriate facility, would be based on half of the mileage to the first facility plus all of the mileage from the first facility to the second facility.

For mileage for nonemergency ground transports, only the mileage from the POP to the nearest appropriate facility is allowed. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the POP to the nearest appropriate facility is not covered.

When three or more patients are transported, for each beneficiary:

- Sixty percent of the allowed amount for a single-person transport (excluding separately billable mileage) is allowed;

- For mileage to a single destination, the a pro rata share of the total mileage is allowed;

- For mileage for both emergency ground transports and all air transports to multiple destinations, the allowed amount for each leg of the transport is a pro rata share of the total mileage based on the number of patients on board upon arrival at each destination.

For mileage for nonemergency ground transports, the allowed amount for each beneficiary is based on the mileage to the nearest appropriate facility divided by the number of beneficiaries loaded on board at the POP (including any intermediate points of pickup). Mileage other than the mileage that would be incurred from transporting each beneficiary directly from the POP to the nearest appropriate facility is not allowed.

Additionally for intermediaries for claims with dates of service on or after April 1, 2002, providers must report value code 32 (multiple patient ambulance transport) when an ambulance transports more than one patient at a time to the same destination. Providers must report value code 32 and the number of patients transported in the amount field as a whole number to the left of the delimiter. Providers may not report additional ambulance services on a claim that contains a multiple patient ambulance transport, even if the POP ZIP code is the same. A separate claim must be submitted for additional ambulance services.

Contractors must use the appropriate message to indicate that there is a reduction. Carriers use message codes M16 and N45.

Medicare Part B coinsurance, deductible, and mandatory assignment apply to these prorated payments.

10.4.2 - Payment When More Than One Ambulance Arrives at the Scene

(Rev.)

PM AB-03-007

The general Medicare program rule is that the Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service.

When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that actually furnishes the transport. Ambulance providers/suppliers that arrive on the scene but do not furnish a transport are not due payment from Medicare.

10.4.3 - Air Ambulance Services

(Rev.)

PMs AB-01-165, AB-02-036, AB-02-131; B3-5116.5, B3-5205 Partial

Refer to the Medicare Benefit Policy Manual, Chapter 10, "Ambulance," §10.4, for additional information on the coverage of air ambulance services. Under certain circumstances, transportation by airplane or helicopter may qualify as covered ambulance services. If the conditions of coverage are met, payment may be made for the air ambulance services.

Prior to the implementation of the fee schedule, in areas where the charging practices for air ambulances do not differ materially from those used by land ambulances, carriers are to apply the normal reasonable charge amount for this class of service.

In those areas in which the suppliers of air ambulance services have unique charging practices, carriers must use discretion in properly applying reasonable charge criteria based on first-hand knowledge of such charging methods. The limited number of air ambulance suppliers in many areas may necessitate the expansion of the definition of "locality" for prevailing charge computations to include customary charges in other localities, even beyond the service area. When faced with the situation of a lone supplier of air ambulance service, carriers should apply the same guidelines that are used for determining the reasonable charge for a rare or unusual procedure. In such situations, in order to make the reasonable charge determination, the carrier:

a. Obtains data, if possible, on the charges made for the unusual or rare procedure in other areas similar to the locality in which the service was rendered; or

b. Consults with the local medical society regarding the appropriate charge to be made for this procedure.

Also, should it be determined in a particular case that the use of a land ambulance would have sufficed in lieu of air ambulance service, the reasonable charge should be limited to the amount which would have been payable for a land ambulance if this amount is less than the air ambulance charge.

On or after the implementation of the fee schedule, air ambulance services are paid at different rates according to two air ambulance categories:

- **AIR** ambulance service, conventional air services, transport, one way, **fixed wing** (FW) (HCPCS code A0430)
- **AIR** ambulance service, conventional air services, transport, one way, **rotary wing** (RW) (HCPCS code A0431)

Covered air ambulance mileage services are paid when the appropriate HCPCS code is reported on the claim:

- HCPCS code A0435 identifies FIXED WING AIR MILEAGE
- HCPCS code A0436 identifies ROTARY WING AIR MILEAGE

Air mileage must be reported in whole numbers. Contractors must ensure that the appropriate air transport code is used with the appropriate mileage code.

Air ambulance services may be paid only for ambulance services to a hospital. Other destinations, e.g., skilled nursing facility, a physician's office, or a patient's home may not be paid air ambulance. The destination is identified by origin and destination modifiers.

Additional air mileage may be allowed by the contractor in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include, but are not limited to, the following:

- Military base and other restricted zones, air-defense zones, and similar FAA restrictions and prohibitions;
- Hazardous weather; or
- Variances in departure patterns and clearance routes required by an air traffic controller.

If the air transport meets the criteria for medical necessity, Medicare pays the actual miles flown for legitimate reasons as determined by the Medicare contractor, once the Medicare beneficiary is loaded onto the air ambulance.

Chapter 6 of the Medicare Program Integrity Manual contains instructions for medical review of air ambulance services.

10.4.4 - Deceased Beneficiary

(Rev.)

AB-03-007

Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service.

In general, if the beneficiary dies before being transported, then no Medicare payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements.

The example below shows the Medicare payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

A. Ground Ambulance Scenarios: Beneficiary Death

Time of Death Pronouncement Medicare Payment Determination

1. Before dispatch. None.

2. After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point-of-pickup). The provider's/supplier's BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting the claim.

3. After pickup, prior to or upon arrival at the receiving facility. Medically necessary level of service furnished.

The example below shows the Medicare payment determination for various air ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

If the flight is aborted for other reasons, such as bad weather, the Medicare payment determination is based on whether the beneficiary was onboard the air ambulance.

B. Air Ambulance Scenarios: Beneficiary Death

Time of Death Pronouncement Medicare Payment Determination

1. Prior to takeoff to point-of-pickup with notice to dispatcher and time to abort the flight. None.

NOTE: This scenario includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.)

2. After takeoff to point-of-pickup, but before the beneficiary is loaded. Appropriate air base rate with no mileage or rural adjustment; use the QL modifier when submitting the claim.

3. After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility. As if the beneficiary had not died.

C. Air Ambulance Scenarios: Aborted Flights

Aborted Flight Scenario Medicare Payment Determination

1. Any time before the beneficiary is loaded onboard (i.e., prior to or after take-off to point-of-pickup). None.

2. Transport after the beneficiary is loaded onboard. Appropriate air base rate, mileage, and rural adjustment.

10.4.4.1 - Air Ambulance for Deceased Beneficiary

(Rev.)

PM AB-02-031

The policy in this section is effective for carriers March 7, 2002, and for intermediaries July 1, 2002.

Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, e.g., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living beneficiary or of a beneficiary not yet pronounced dead been completed.

For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements.

This policy also states that no amount shall be allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. Further, no amount shall be allowed if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

Providers and suppliers must use the modifier QL (Patient pronounced dead after ambulance called) to indicate the circumstance when an air ambulance takes off to pick up a beneficiary but the beneficiary is pronounced dead before the pickup can be made.

The supplier must submit documentation with the claim sufficient to show that:

a. The air ambulance was dispatched to pick up a Medicare beneficiary;

b. The aircraft actually took off to make the pickup;

c. The beneficiary to whom the dispatch relates was pronounced dead before being loaded onto the ambulance for transport;

d. The pronouncement of death was made by an individual authorized by State law to make such pronouncements; and

e. The dispatcher did not receive notice of such pronouncement in sufficient time to permit the flight to be aborted before take off.

Contractors must allow the appropriate air base rate (fixed wing or rotary wing, as applicable) for a claim for an air ambulance service for deceased beneficiaries but not allow mileage or make a rural adjustment. During the fee schedule transition, contractors must allow an amount based on a blended rate.

For intermediaries, this policy applies to the following types of bills: 12X, 13X, 22X, 23X, 83X, and 85X. Refer to §20 below for additional billing guidelines.

10.4.4.2 - Modifiers

(Rev.)

The QL Modifier (Patient Pronounced Dead After the Ambulance Called) is used in the following way:

- Carriers or intermediaries must approve to pay a covered Basic Life Support (BLS) service if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene; when identified with QL modifier.

- Carriers or intermediaries must suspend processing of a claim with mileage if the beneficiary was pronounced dead after the ambulance was called but before the ambulance arrived at the scene, when identified with QL modifier.

- Carriers or intermediaries must approve to pay a covered fixed wing base rate claim if an air ambulance was dispatched when the beneficiary was pronounced dead after the ambulance was called but before the ambulance arrived at the scene; when identified with QL modifier.

- Carriers or intermediaries must suspend processing of a claim with a fixed wing mileage if an air ambulance was dispatched when the beneficiary was pronounced dead after the ambulance was called but before the ambulance arrived at the scene; when identified with QL modifier.

- Carriers or intermediaries must approve to pay a covered rotary wing base rate claim if an air ambulance was dispatched when the beneficiary was pronounced

dead after the ambulance was called but before the ambulance arrives at the scene; when identified with the QL modifier.

- Carriers or intermediaries must suspend a claim, with rotary wing mileage if an air ambulance was dispatched when the beneficiary was pronounced dead after the ambulance was called but before the ambulance arrived at the scene; when identified with the QL modifier.

- Carriers or intermediaries must approve to pay covered air ambulance with QL modifier at the urban rate.

10.4.5 - Waiting Time Charges Made by Ambulance Companies - Carriers Only

(Rev.)

B3-5215, B3-5024 Partial

This section applies under the reasonable charge portion of the fee schedule and only for those carriers who paid for this service prior to April 1, 2002. It does not apply to fee schedule payments.

Waiting time charges are charges an ambulance service company makes for time spent while waiting for the patient. Ambulance companies, in arriving at their charge rates, usually consider that the total time involved in picking up a patient and transporting him to his destination involves some waiting time. This waiting time is not a separate identifiable part of the charge rate for covered ambulance service and, therefore, not reimbursable as a separate charge unless the waiting time is extraordinarily long and constitutes unusual circumstances. The reasonableness of the additional amount charged in any given instance must be determined based on knowledge of all the pertinent facts including:

a. The customary additional charge, under the circumstances, of the physician or other person rendering the service;

b. The prevailing charging practices under such circumstances of physicians and other persons in the locality; and

c. The additional time spent or expenses incurred by the physician or other person rendering the service.

When carriers receive a claim on which the submitted charge substantially exceeds the normal reasonable charge amount for waiting time, they must send it to the utilization review unit for its review. Once the review unit has made a determination to pay an amount higher than the customary or prevailing charge, documentation to support the reason for this determination **must** accompany the claim.

Carriers must exercise discretion in processing claims involving waiting time so that reimbursement is not made for unwarranted waiting time. Such caution is necessary since determining what constitutes unusual circumstances is a judgmental decision. To facilitate that determination and to avoid unnecessary development and delays, carriers instruct the suppliers of ambulance services to include on their bills an explanation of any unusual circumstances that had a bearing on their charges.

10.4.5.1 - Requirements for Approval of Waiting Time

(Rev.)

B3-5215.1

If the carrier establishes that the waiting time constitutes unusual circumstances sufficient to warrant coverage, payment may be made if certain conditions are satisfied. However, the maximum allowable combined charges for the ambulance service and waiting time may not exceed the amount that the total charges would have been if the ambulance had returned to its base of operations and then returned to pick up the patient and transport him. These conditions are:

1. The ambulance company makes a separate charge to all patients, both Medicare and non-Medicare, for unusual waiting time;

2. It is the general practice of ambulance companies in the locality to make an extra charge for unusual waiting time; and

3. The claim is completely documented as to why the ambulance was required to wait and the exact time involved. The ambulance company should ordinarily obtain this documentation from the physician or hospital personnel responsible for admitting or discharging patients.

However, if this is not possible, the documentation may be a statement from the ambulance company based on a record containing all pertinent facts necessary to support the claim. The ambulance company could establish the necessary record by instructing its crews to ascertain from the physician or responsible hospital personnel the reason for the wait at the time it occurs. The reason could be entered on the ambulance log over the signature of the physician or other informant.

10.4.6 - Other Unusual Circumstances

(Rev.)

B3-5116.6

Amounts above the reasonable charge may be allowed when unusual circumstances are documented. Carriers are expected to make such determinations, with medical staff assistance as needed and on a case by case basis, in deciding whether the services actually furnished exceed the range of services ordinarily provided. Such situations

include but are not limited to: Night services, use of extra attendants to handle disturbed patients, and where the facts indicate that a situation existed above and beyond normal ambulance transportation which justified additional charges.

These services may only be paid through the transition (and only in the reasonable charge percentage) **AND** may only be paid by carriers who were paying for these services prior to April 1, 2002.

When the fee schedule is fully implemented, payments will be limited to the calculated fee schedule amount.

20 - General Bill Processing Guidelines

(Rev.)

A3-3660, B3-5116, PMs AB-00-88, AB-02-036, AB-99-53, AB-99-83, AB-94-8, AB-02-031

Hospitals(including critical access hospitals) and SNFs that bill the intermediary use Form CMS-1450 (UB-92), the UB-92 electronic data set, or the ANSI X12N 837 data set.

Ambulance suppliers may bill the carrier on Form CMS-1491 for Suppliers, Form CMS-1500, Health Insurance Claim Form; the NSF EDI data set; or the ANSI X12N 837 data set.

A - Modifiers Specific to Ambulance

Providers/Suppliers must report two of the following modifiers for ambulance trip to report the origin and the destination:

D = Diagnostic or therapeutic site other than P or H when these are used as origin codes;

E = Residential, domiciliary, custodial facility (other than 1819 facility);

G = Hospital based ESRD facility;

H = Hospital;

I = Site of transfer;

J = Freestanding ESRD facility;

N = Skilled nursing facility;

P = Physician's office;

R = Residence;

S = Scene of accident or acute event;

X = Intermediate stop at physician's office on way to hospital (destination code only)

Refer to §10.4.1 for a description of how to use the GM modifier for multiple patient transports.

B - HCPCS Codes

The following codes and definitions are effective for billing ambulance services on or after January 1, 2001.

Ambulance HCPCS Codes Crosswalk and Definitions

HCPCS Codes	**Description of HCPCS Codes**
A0382	BLS routine disposable supplies
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)
A0392	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed by BLS ambulances)
A0394	ALS specialized service disposable supplies; IV drug therapy
A0396	ALS specialized service disposable supplies; esophageal intubations
A0398	ALS routine disposable supplies
A0420	Ambulance waiting time (ALS or BLS), one-half hour increments
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0424	Extra ambulance attendant, ALS or BLS (requires medical review)
A0425	Effective for claims with dates of service on or after January 1, 2001, replaces code A0390 averaged with A0380 - ALS mileage (per mile) or BLS mileage (per mile)

HCPCS Codes	Description of HCPCS Codes
A0426	Effective for claims with dates of service on or after January 1, 2001, code replaces A0306 (method 1), A0326 (method 2), A0346 (method 3), A0366 (method 4) - Ambulance service, ALS, nonemergency transport, specialized ALS services rendered
A0427	Effective for claims with dates of service on or after January 1, 2001, code replaces A0310 (method 1), A0330 (method 2), A0350 (method 3), A0370 (method 4) - Ambulance service, ALS, emergency transport, specialized ALS services rendered
A0428	Effective for claims with dates of service on or after January 1, 2001, code replaces A0300 (Method 1), A0320 (Method 2), A0340 (method 3), A0360 (method 4) - Ambulance service, BLS, nonemergency transport
A0429	Effective for claims with dates of service on or after January 1, 2001, code replaces, A0050, A0302 (method 1), A0322 (Method 2), A0342 (method 3), A0362 (method 4) - Ambulance service, BLS, emergency transport
A0430	Effective for claims with dates of service on or after January 1, 2001, code replaces A0030 - Ambulance service, conventional air services, transport, one way, fixed wing (FW)
A0431	Effective for claims with dates of service on or after January 1, 2001, code replaces A0040 - Ambulance service, conventional air services, transport, one way, rotary wing (RW)
A0432	Effective for claims with dates of service on or after January 1, 2001, code replaces code Q0186 - Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers.
A0433	Effective for claims with dates of service on or after January 1, 2001, code replaces A0310 (method 1), A0330 (method 2), A0350 (method 3), A0370 (method 4) - Ambulance service, advanced life support, level 2 (ALS2)
A0434	Effective for claims with dates of service on or after January 1, 2001, code replaces A0310 (method 1), A0330 (method 2), A0350 (method 3), A0370 (method 4) - Ambulance service, specialty care transport (SCT)
A0435	Effective for claims with dates of service on or after January 1, 2001, replaces local carrier code - Air mileage; FW, (per statute mile)

HCPCS Codes	Description of HCPCS Codes
A0436	Effective for claims with dates of service on or after January 1, 2001, replaces local carrier code - Air mileage; RW, (per statute mile)
A0999	Unlisted ambulance service
Q3019	Effective for claims with dates of service on or after January 1, 2001, code replaces A0308 (method 1), A0328 (method 2), A0348 (method 3), A0368 (method 4) - Ambulance service, ALS, emergency transport, no specialized ALS services rendered
Q3020	Effective for claims with dates of service on or after January 1, 2001, code replaces A0304 (method 1), A0324 (method 2), A0344 (method 3), A0364 (method 4) - Ambulance service, advanced life support (ALS), nonemergency transport, no specialized ALS services rendered

Refer to the Medicare Benefit Policy Manual, Chapter 10, §30.1, for the definitions of levels of ambulance services under the fee schedule.

During the transition period, if an ALS vehicle is used for an emergency transport but no ALS level service is furnished, the fee schedule (FS) portion of the blended payment will be based on the emergency BLS level. The amount on the FS for HCPCS code Q3019 is the same fee as BLS-Emergency (BLS-E) FS HCPCS code A0429. The reasonable charge/cost portion of the blended payment will be the ALS emergency rate.

During the transition period, if an ALS vehicle is used for a nonemergency transport but no ALS level service is furnished, the FS portion of the blended payment will be based on the nonemergency BLS level. The amount displayed on the FS for HCPCS code Q3020 is the same fee displayed for BLS nonemergency, FS HCPCS code A0428. The reasonable charge/cost portion of the blended payment will be the ALS nonemergency rate.

Codes Q3019 and Q3020 are relevant for "billing" purposes only. (There were old codes that existed for these services that can no longer be used for payment purposes).

20.1 - Preparing Claims to Carriers

(Rev.)

B3-5116

20.1.1 - Coding

(Rev.)

The following instructions describe coding for the Forms CMS-1500 and CMS-1491.

20.1.1.1 - Coding Requirements for Suppliers

(Rev.)

PM AB-00-88

The implementation of the ambulance fee schedule resulted in the need for HCPCS coding changes, primarily because of the following:

- Seven categories of ground ambulance services;
- Two categories of air ambulance services;
- Payment based on the condition of the beneficiary, not on the type of vehicle used;
- Payment is determined by the POP (as reported by the 5-digit ZIP code);
- Increased payment for rural services;
- New HCPCS codes effective for dates of service beginning January 1, 2001;
- No grace period for old HCPCS codes for dates of service after January 1, 2001. HCPCS codes A0380 and A0390 will be used until the fee schedule is implemented.

  (**Exception** - suppliers using Methods 3 and 4 may continue to use the old HCPCS codes for items and services, including J-codes and codes for EKG testing, during the transition period); and
- Services and supplies included in base rate.

20.1.1.2 - Instructions for Completing Form CMS-1500

(Rev.)

PMs AB-00-88, AB-00-118, AB-00-131

Beginning with dates of service January 1, 2001, the following coding instructions must be used.

There will be no grace period to transition the use of the new HCPCS codes. Carriers return as unprocessable any claim submitted with old HCPCS codes for dates of service January 1, 2001, and later (with the exception of those HCPCS codes for items and services that Methods 3 and 4 billers may continue to bill during the transition).

Suppliers using Method 3 or 4 may use supply codes A0382, A0384, and A0392 - A0999, as well as J-codes and codes for EKG testing during the transition period.

In item 23 of Form CMS-1500, billers code the 5-digit ZIP code of the POP.

Electronic billers using National Standard Format (NSF) are to report the origin information in record EA1. EA1-06 is used to report the address information. EA1-08 is used to report the city name. EA1-09 is used to report the State code. EA1-10 is used to report the ZIP code.

Electronic billers using X12N 837 are to report the origin information (e.g., the ZIP code of the POP) in loop 2310A (Facility Address). NM1 is required. NM101 will have the value "61" (Performed At) and NM102 will have the value "2" (nonperson entity). The remaining fields are not required: N2 (Facility Name) is not required; N3 (Facility Address) is not required. N4 (Facility City, State, ZIP) is required. N401 is used to report the city name. N402 is used to report the State Code and N403 is used to report the ZIP code.

Since the ZIP code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary if all points of pickup have the same ZIP code. Suppliers must prepare a separate claim for each trip if the points of pickup are located in different ZIP codes.

Claims without a ZIP code in item 23, or with multiple ZIP codes in item 23, must be returned as unprocessable. Carriers use message N53 on the remittance advice in conjunction with reason code 16.

ZIP codes must be edited for validity.

The format for a ZIP code is five numeric characters. If a 9-digit ZIP code is submitted, the last four digits are ignored. If the data submitted in the required field does not match that format, the claim is rejected.

If the ZIP code entered on the claim is not in the CMS-supplied ZIP Code File, the carriers manually verify the ZIP code to identify a potential coding error on the claim or a new ZIP code established by the U.S. Postal Service (USPS). ZIP code information may be found at the USPS Web site at www.usps.com, or other commercially available sources of ZIP code information may be consulted. If this process validates the ZIP code, the claim can be processed. All such ZIP codes are to be considered urban ZIP codes until CMS determines that the code should be designated as rural. If this process does not validate the ZIP code, the claim must be rejected as unprocessable.

Generally, each ambulance trip will require two lines of coding, e.g., one line for the service and one line for the mileage. Suppliers who do not bill mileage would have one line of code for the service.

If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code "1" as the mileage for trips less than a mile.

20.1.1.3 - Instructions for Completing Form CMS-1491

(Rev.)

PMs AB-00-88, AB-00-131

Form CMS-1491 has not been revised for the new fee schedule. The following coding instructions should be followed until the form is revised.

The service HCPCS code is entered in item 22 as well as any information necessary to describe the illness or injury.

The new HCPCS code must be used to reflect the type of service the beneficiary received, not the type of vehicle used.

There is no grace period to transition the use of the new HCPCS codes. Carriers return as unprocessable any claim submitted with old HCPCS codes for dates of service January 1, 2001, and later (with the exception of those HCPCS codes for items and services that Methods 3 and 4 billers may continue to bill through transition years 1, 2, 3, and 4).

Generally, a claim for an ambulance service will require two entries, e.g., one HCPCS code for the service and one HCPCS code for the mileage. Suppliers who do not bill mileage would have an entry only for the service.

The mileage HCPCS code is entered into item 14 as well as the number of loaded miles.

If mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code "1" as the mileage for trips less than a mile.

NOTE: To bill mileage, suppliers continue to use codes A0380 and A0390 for dates of service January 1, 2001 through March 31, 2002.

Suppliers using Method 3 or 4 may use supply codes A0382, A0384, and A0392 - A0999 as well as J-codes and codes for EKG testing during the transition period. These supply codes should be entered in item 22. Carriers deny claims for items from Method 1 and Method 2 billers.

The ZIP code of the POP must be entered in item 12. If there is no ZIP code in item 12, or if there are multiple ZIP codes in item 12, carriers return the claim as unprocessable.

The ZIP code entered in item 12 must be edited for validity.

The format for a ZIP code is five numerics. If the ZIP code in item 12 shows a 9-digit ZIP code, carriers validate only the first 5 digits. If the ZIP code entered into item 12 does not correspond to a USPS either 5- or 9-digit format, carriers reject the claim as unprocessable using message N53 on the remittance advice in conjunction with reason code 16.

20.2 - Preparing Claims to Intermediary

(Rev.)

A3-3660.1, SNF-539, HHA-477, HO-433, PMs A-01-48, AB-00-88, AB-00-118, AB-00-131

These instructions are for claims with dates of service on or after April 1, 2002.

For SNF Part A, the cost of transportation to receive most services included in the RUG rate is included in the cost for the service. This includes transportation in an ambulance. Payment for the SNF claim is based on the RUGs, and recalibration for future years takes into account the cost of transportation to receive the ancillary services.

If the services are excluded from the SNF PPS rate, the ambulance service may be billed separately as can the excluded service.

The same rationale applies to hospitals as well.

In general, the intermediary processes claims for Part B ambulance services provided by am ambulance supplier under arrangements with hospitals or SNFs. These providers bill intermediaries using only Method 2.

20.2.1 - Coding Claims to Intermediaries

(Rev.)

SNF QA day

A - Revenue Code Reporting

Providers report ambulance services under revenue code 540 in FL 42 "Revenue Code."

B - HCPCS Codes Reporting

Providers report the following HCPCS codes established for the ambulance fee schedule. No other HCPCS codes are acceptable for the reporting of ambulance services and mileage. The codes reflect the type of service the beneficiary received, not the type of vehicle used. (Not all previous HCPCS codes are applicable to providers since providers have been reporting the all-inclusive rate and mileage codes as described in §30.2.)

Providers must report one of the following HCPCS codes in FL 44 "HCPCS/Rates" for each base rate ambulance trip provided during the billing period:

A0426;
A0427;
A0428;
A0429;
A0430;
A0431;
A0432;
A0433; or
A0434.

These are the same codes required effective for services January 1, 2001.

In addition, providers must report **one** of HCPCS mileage codes:

A0425;
A0435; or
A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported per revenue code line, providers must report revenue code 540 (ambulance) on two separate and consecutive line items to accommodate both the ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported. Providers code one mile for trips less than a mile. Miles must be entered as whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number.

C - Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided and either a QM (Ambulance service provided under arrangement by a provider of services) or QN (Ambulance service furnished directly by a provider of services) modifier in FL 44 "HCPCS/Rates".

D - Service Units Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, providers are required to report in FL 46 "Service Units" for each ambulance trip provided. Therefore, the service units for each occurrence of these

HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0425, A0435, or A0436, providers must also report the number of loaded miles.

E - Total Charges Reporting

For line items reflecting HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434, providers are required to report in FL 47, "Total Charges," the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS codes A0425, A0435, or A0436, providers are to report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene. In these situations, providers report the base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units. For the related charges, providers report $1.00 in noncovered charges. Intermediaries should assign ANSI Group Code OA to the $1.00 noncovered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

F - Edits (Intermediary Claims With Dates of Service On or After 4/1/02)

For claims with dates of service on or after April 1, 2002, intermediaries perform the following edits to assure proper reporting:

- Edit to assure each pair of revenue codes 540 have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434; and one of the following mileage HCPCS codes - A0425, A0435, or A0436.

- Edit to assure the presence of an origin, destination modifier, and a QM or QN modifier for every line item containing revenue code 540;

- Edit to assure that the unit's field is completed for every line item containing revenue code 540;

- Edit to assure that service units for line items containing HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 always equal "1"; and

- Edit to assure on every claim that revenue code 540, a value code of A0 (zero), and a corresponding ZIP code are reported. If the ZIP code is not a valid ZIP code in accordance with the USPS assigned ZIP codes, intermediaries verify the ZIP code to determine if the ZIP code is a coding error on the claim or a new ZIP code from the USPS not on the CMS supplied ZIP Code File.

G - CWF (Intermediaries)

Intermediaries report the procedure codes in the financial data section (field 65a-65j). They include revenue code, HCPCS code, units, and covered charges in the record. Where more than one HCPCS code procedure is applicable to a single revenue code, the provider reports each HCPCS code and related charge on a separate line, and the intermediary reports this to CWF. Report the payment amount before adjustment for beneficiary liability in field 65g "Rate" and the actual charge in field 65h, "Covered Charges."

H - Provider Statistics and Reimbursement Report (PS&R) (Intermediaries)

To assure that the providers receive the correct payment amount during the transition period, all submitted charges attributable to ambulance services furnished during a cost-reporting period are aggregated and treated separately from the submitted charges attributable to all other services furnished in the provider. In addition, the necessary statistics are maintained for the PS&R. This ensures that the ambulance fee schedule portion of the blended transition payment is not cost settled at cost settlement time. See the PS&R guidelines for specific information.

20.2.1.1 - Coding Instructions for Providers Billing Reasonable Cost

(Rev.)

Applicable Bill Types

The appropriate type of bill (13X, 22X, 23X, 32X, 33X, 34X, 83X, and 85X) must be reported. For SNFs, ambulance cannot be reported on a 21x type of bill.

Value Code Reporting

For claims with dates of service on or after January 1, 2001, providers must report on every Part B ambulance claim value code A0 (zero) and the related ZIP code of the geographic location from which the beneficiary was placed on board the ambulance in FLs 39-41 "Value Codes." The value code is defined as "ZIP Code of the location from which the beneficiary is initially placed on board the ambulance." Providers report the number in dollar portion of the form location right justified to the left to the dollar/cents delimiter. Providers utilizing the UB-92 flat file use Record Type 41 fields 16-39. On the X-12 institutional claims transactions, providers show HI*BE:A0:::12345~, 2300 Loop, HI segment.

More than one ambulance trip may be reported on the same claim if the ZIP code of all points of pickup are the same. However, since billing requirements do not allow for value codes (ZIP codes) to be line item specific and only one ZIP code may be reported per claim, providers must prepare a separate claim for a beneficiary for each trip if the points of pickup are located in different ZIP codes.

Revenue Code/HCPCS Code Reporting

Providers must report revenue code 054x and, for services **provided before January 1, 2001,** one of the following CMS HCPCS codes in FL 44 "HCPCS/Rates" for each ambulance trip provided during the billing period:

A0030 (discontinued 12/31/2000);
A0040 (discontinued 12/31/2000);
A0050 (discontinued 12/31/2000);
A0320 (discontinued 12/31/2000);
A0322 (discontinued 12/31/2000);
A0324 (discontinued 12/31/2000);
A0326 (discontinued 12/31/2000);
A0328, (discontinued 12/31/2000); or
A0330 (discontinued 12/31/2000)

In addition, providers report one of A0380 or A0390 for mileage HCPCS codes. No other HCPCS codes are acceptable for reporting ambulance services and mileage.

Providers report one of the following revenue codes:

0540;
0542;
0543;
0545;
0546; or
0548.

Do not report revenue codes 0541, 0544, or 0547.

For claims with **dates of service on or after January 1, 2001**, providers must report revenue code 540 and one of the following HCPCS codes in FL 44 "HCPCS/Rates" for each ambulance trip provided during the billing period:

A0426;
A0427;
A0428;
A0429;
A0430;
A0431;
A0432;
A0433; or
A0434.

Providers using an ALS vehicle to furnish a BLS level of service report HCPCS code, A0426 (ALS1) or A0427 (ALS1 emergency), and are paid accordingly.

In addition, all providers report one of the following mileage HCPCS codes:

A0380;
A0390;
A0435; or
A0436.

Since billing requirements do not allow for more than one HCPCS code to be reported for per revenue code line, providers must report revenue code 0540 (ambulance) on two separate and consecutive lines to accommodate both the Part B ambulance service and the mileage HCPCS codes for each ambulance trip provided during the billing period. Each loaded (e.g., a patient is onboard) 1-way ambulance trip must be reported with a unique pair of revenue code lines on the claim. Unloaded trips and mileage are **NOT** reported.

However, in the case where the beneficiary was pronounced dead after the ambulance is called but before the ambulance arrives at the scene: Payment may be made for a BLS service if a ground vehicle is dispatched or at the fixed wing or rotary wing base rate, as applicable, if an air ambulance is dispatched. Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Providers report the A0428 (BLS) HCPCS code. Providers report modifier QL (Patient pronounced dead after ambulance called) in Form Locator (FL) 44 "HCPCS/Rates" instead of the origin and destination modifier. In addition to the QL modifier, providers report modifier QM or QN.

Modifier Reporting

Providers must report an origin and destination modifier for each ambulance trip provided in FL 44 "HCPCS/Rates." Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of x, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below:

D - Diagnostic or therapeutic site other than "P" or "H" when these are used as origin codes;

E - Residential, Domiciliary, Custodial Facility (other than an 1819 facility);

H - Hospital;

I - Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport;

J - Nonhospital based dialysis facility;

N - Skilled Nursing Facility (SNF) (1819 facility);

P - Physician's office (Includes HMO nonhospital facility, clinic, etc.);

R - Residence;

S - Scene of accident or acute event; or

X - (Destination Code Only) intermediate stop at physician's office enroute to the hospital. (Includes HMO nonhospital facility, clinic, etc.)

In addition, providers must report one of the following modifiers with every HCPCS code to describe whether the service was provided under arrangement or directly:

QM - Ambulance service provided under arrangement by a provider of services; or

QN - Ambulance service furnished directly by a provider of services.

Line-Item Dates of Service Reporting

Providers are required to report line-item dates of service per revenue code line. This means that they must report two separate revenue code lines for every ambulance trip provided during the billing period along with the date of each trip. This includes situations in which more than one ambulance service is provided to the same beneficiary on the same day. Line-item dates of service are reported on the hard copy UB-92 in FL 45 "Service Date" (MMDDYY), and on RT 61, field 13, "Date of Service" (YYYYMMDD) on the UB-92 flat file.

Service Units Reporting

For line items reflecting HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330 (**services before January 1, 2001)** or codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**services on and after January 1, 2001**) providers are required to report in FL 46 "Service Units" each ambulance trip provided during the billing period. Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380 or A0390, the number of loaded miles must be reported. (See examples below.)

Therefore, the service units for each occurrence of these HCPCS codes are always equal to one. In addition, for line items reflecting HCPCS code A0380, A0390, A0435, or A0436, the number of loaded miles must be reported.

Total Charges Reporting

For line items reflecting HCPCS codes:

A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330 **(services before January 1, 2001);**

or

HCPCS codes A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, or A0434 (**on or after January 1, 2001).**

Providers are required to report in FL 47 "Total Charges" the actual charge for the ambulance service including all supplies used for the ambulance trip but excluding the charge for mileage. For line items reflecting HCPCS codes A0380, A0390, A0435, or A0436, report the actual charge for mileage.

NOTE: There are instances where the provider does not incur any cost for mileage, e.g., if the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene. In these situations, providers report the base rate ambulance trip and mileage as separate revenue code lines. Providers report the base rate ambulance trip in accordance with current billing requirements. For purposes of reporting mileage, they must report the appropriate HCPCS code, modifiers, and units as a separate line item. For the related charges, providers report $1.00 in FL48 for noncovered charges. Intermediaries should assign ANSI Group Code OA to the $1.00 noncovered mileage line, which in turn informs the beneficiaries and providers that they each have no liability.

Prior to submitting the claim to CWF, the intermediary will remove the entire revenue code line containing the mileage amount reported in FL 48 "Noncovered Charges" to avoid nonacceptance of the claim.

EXAMPLES: The following provides examples of how bills for Part B ambulance services should be completed based on the reporting requirements above. These examples reflect ambulance services furnished directly by providers. Ambulance services provided under arrangement between the provider and an ambulance company are reported in the same manner except providers report a QM modifier instead of a QN modifier. The following examples are for claims submitted with dates of service on or after January 1, 2001.

EXAMPLE 1 - Claim containing only one ambulance trip:

For the UB-92 Flat File, providers report as follows:

Record Type	Revenue Code	HCPCS Code	Modifier		Date of Service	Units	Total Charges
			#1	#2			
61	0540	A0428	RH	QN	082701	1 (trip)	100.00
61	0540	A0380	RH	QN	082701	4 (mileage)	8.00

For the hard copy UB-92 (Form CMS-1450), providers report as follows:

FL 42	FL 44	FL 45	FL 46	FL 47
0540	A0428RHQN	082701	1 (trip)	100.00
0540	A0380RHQN	082701	4 (mileage)	8.00

EXAMPLE 2 - Claim containing multiple ambulance trips:

For the UB-92 Flat File, providers report as follows:

Record Type	Revenue Code	HCPCS Code	Modifier		Date of Service	Units	Total Charges
			#1	#2			
61	0540	A0429	RH	QN	082801	1 (trip)	100.00
61	0540	A0380	RH	QN	082801	2 (mileage)	4.00
61	0540	A0330	RH	QN	082901	1 (trip)	400.00
61	0540	A0390	RH	QN	082901	3 (mileage)	6.00
61	0540	A0426	RH	QN	083001	1 (trip)	500.00
61	0540	A0390	RH	QN	083001	5 (mileage) 10.00	
61	0540	A0390	RH	QN	082901	3 (mileage)	6.00
61	0540	A0426	RH	QN	083001	1 (trip)	500.00

For the hard copy UB-92 (Form CMS-1450), providers report as follows:

FL 42	FL 44	Modifier		FL 45	FL 46	FL 47
		#1	#2			
0540	A0429	RH	QN	082801	1 (trip)	100.00
0540	A0380	RH	QN	082801	2 (mileage)	4.00

EXAMPLE 3 - Claim containing more than one ambulance trip provided on the same day:

For the UB-92 Flat File, providers report as follows:

Record Type	Revenue Code	HCPCS Code	Modifier		Date of Service	Units	Total Charges
			#1	#2			
61	0540	A0429	RH	QN	090201	1 (trip)	100.00
61	0540	A0380	RH	QN	090201	2 (mileage)	4.00
61	0540	A0429	HR	QN	090201	1 (trip)	100.00
61	0540	A0380	HR	QN	090201	2 (mileage)	4.00

For the hard copy UB-92 (CMS-1450), providers report as follows:

FL 42	FL 44	Modifier		FL 45	FL 46	FL 47
		#1	#2			
0540	A0429	RH	QN	090201	1 (trip)	100.00
0540	A0380	RH	QN	090201	2 (mileage)	4.00
0540	A0429	HR	QN	090201	1 (trip)	100.00
0540	A0380	HR	QN	090201	2 (mileage)	4.00

Edits

Intermediaries edit to assure proper reporting as follows:

- For claims with dates of service before January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance trip HCPCS codes - A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328 or A0330; and one of the following mileage HCPCS codes - A0380 or A0390;

- For claims with dates of service on or after January 1, 2001, each pair of revenue codes 0540 must have one of the following ambulance HCPCS codes - A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433 or A0434; and one of the following mileage HCPCS codes - A0380, A0390, A0435, or A0436;

- For claims with dates of service on or after January 1, 2001, the presence of an origin and destination modifier and a QM or QN modifier for every line item containing revenue code 0540;

- The units field is completed for every line item containing revenue code 0540;

- For claims with dates of service on or after January 1, 2001, the units field is completed for every line item containing revenue code 0540;

- Service units for line items containing HCPCS codes A0030, A0040, A0050, A0320, A0322, A0324, A0326, A0328, A0330, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433 or A0434 always equal "1"

For claims with dates of service on or after July 1, 2001, each 1-way ambulance trip, line-item dates of service for the ambulance service, and corresponding mileage are equal.

20.2.2 - Services Provided Under Arrangement

(Rev.)

B3-5117

For SNF Part A, the cost of transportation to receive most services included in the RUG rate is included in the cost for the RUG service. This includes transportation in an ambulance. Payment for the SNF claim is based on the RUGs, and recalibration for future years takes into account the cost of transportation to receive the ancillary services.

If the basic SNF services are excluded from the SNF PPS rate, the ambulance service may be billed separately as can the excluded service.

The same rationale applies to hospitals as well with respect to DRG or other PPS payments.

In general, hospitals and SNFs bill intermediaries and intermediaries process claims for Part B ambulance services provided by an ambulance supplier under arrangements with hospitals or SNFs. These providers bill intermediaries using only Method 2.

When provider (e.g., hospital or SNF) ambulance services are furnished under arrangements, the charge to the provider by the ambulance company becomes the provider's cost. This charge must be reasonable, and the cost to the provider should not in any way, because of the arrangement, exceed what would have been the charge if the ambulance company had been permitted to bill the program directly. That is, the ambulance supplier's charges may not exceed the amount established as reasonable for such services by the carrier serving the same locality.

Close coordination between the intermediary and the carrier will be required to insure that the intermediary does not find costs to be reasonable which exceed the amounts which would be payable for the same services by the carrier. Carriers are required to

make available the appropriate information on ambulance charges to the intermediary serving the same area.

In addition, the carrier should keep the intermediary informed of future revisions of reasonable charge data for ambulance services.

These rules apply through the transition period.

Where payment is made entirely under the fee schedule related costs should not be included in Medicare costs for the cost report.

20.3 - Jurisdiction for Claims

(Rev.)

AB-00-88, AB-00-131, AB-01-165, AB-02-33

Claims jurisdiction remains unchanged for the duration of the transition to the fee schedule.

Participating hospitals, CAHs, and SNFs that furnish ambulance services submit claims to their intermediary. Suppliers submit claims to the carrier that has jurisdiction for the locality in which its ambulance is based.

During the transition period, air ambulance suppliers must continue to submit claims to the carrier that has jurisdiction for the locality in which its air ambulance is based (i.e., garaged or hangared). For suppliers that provide services in multiple states, no additional enrollment is necessary for claims submission until the end of the transition period unless the supplier has established a base in another state. (Only if the supplier has established a base/hangar in another state, must it then also enroll with the carrier for the other state.) The carrier with jurisdiction for the claim has the supplier's reasonable charge amount and also the fee schedule amounts for all states in which the ambulance supplier provides services to determine the blended payment.

The carrier jurisdiction will change to the carrier with jurisdiction for the point of pickup at the end of the transition period. Intermediary jurisdiction will remain the same.

30 - Certifications and Documentation

(Rev.)

30.1 - Physician Certification Statement (PCS) Requirements

(Rev.)

PMs B-01-16, AB-00-103

PSCs are required for scheduled and unscheduled nonemergency transports. PCSs are not required for emergency transports or for nonemergency, unscheduled transportation of beneficiaries residing at home or in facilities where they are not under direct care of a physician. These situations should be rare because most transports occur for beneficiaries receiving dialysis or diagnostic tests.

The CMS does not require a particular form or format for the PCS. Because some ambulance suppliers have their own PCS form (or are in the process of developing one), carriers and intermediaries are encouraged to review the supplier's PCS form if requested to do so.

A - Scheduled and Unscheduled Nonemergency Transports

For scheduled and unscheduled nonemergency ambulance transports, ambulance service suppliers must obtain a physician's written order certifying the need for an ambulance. In addition to the physician's signature, it is acceptable to obtain signed PCS statements when professional services are furnished by physician assistants, nurse practitioners, or clinical nurse specialists (where all applicable State licensure or PCS requirements are met).

The PCS must be dated no more than 60 days prior to the date that the service is provided. In cases where a beneficiary requires a nonemergency, unscheduled transport, the PCS can be obtained 48 hours after the ambulance transportation has been provided.

In addition to obtaining the PCS, ambulance suppliers are required to retain the certificate on file and, upon request, present the requested PCS. This requirement applies to both repetitive and 1-time ambulance transports. However, there is one exception to the PCS rule. A PCS is not required for nonemergency, unscheduled transportation of beneficiaries residing at home or in facilities where they are not under the direct care of a physician. These situations should be rare because most transports occur for beneficiaries receiving dialysis or diagnostic tests.

B - General Instructions for Entities Billing the Carrier

Whenever possible, ambulance suppliers should obtain the signed PCS statement prior to the transport. However, there may be instances in which ambulance suppliers have provided transports but are experiencing difficulty in obtaining the required physician PCS statement. For claims for services furnished on or after the August 30, 1999, if the

ambulance supplier is unable to obtain a signed PCS, carriers are to process these claims in accordance with the following instructions:

- Within 90 days following the submission of such claims and to certify the medical necessity of the furnished service, ambulance suppliers must obtain a signed PCS statement from the attending physician. If the ambulance supplier is unable to obtain a signed PCS statement from the attending physician the supplier must obtain:

- A signed PCS statement from either a physician assistant (PA), clinical nurse specialist (CNS), nurse practitioner (NP), registered nurse (RN) or discharge planner who is employed by the hospital or facility where the beneficiary is being treated, with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished; or

- The ambulance supplier must document its attempt to obtain such a statement from the attending physician. Acceptable documentation must include a signed return receipt from a U.S. Postal Service or other similar delivery service. Such a return receipt will serve as proof that the supplier attempted to obtain the required signature from the attending physician.

For services furnished on or after January 31, 2000, ambulance suppliers must follow the procedures described below:

- Before submitting a claim, ambulance suppliers must obtain a signed PCS statement from the attending physician. If the ambulance supplier is unable to obtain the signed PCS statement from the attending physician, a signed PCS statement must be obtained from either the PA, NP, CNS, RN, or discharge planner who is employed by the hospital or facility where the beneficiary is being treated with knowledge of the beneficiary's condition at the time the transport was ordered or the service was furnished; or

- If the supplier is unable to obtain the required PCS statement within 21 calendar days following the date of service, the ambulance supplier must document its attempt to obtain the requested PCS statement in the same manner as described above and may then submit the claim.

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier. It is important to note that neither the presence nor absence of the signed PCS statement necessarily proves (or disproves) whether the transport was medically necessary. The ambulance service must meet all other coverage criteria in order for payment to be made.

In focusing their medical review resources, carriers and intermediaries should consider focusing on ambulance suppliers with a higher number of unsuccessful attempts to obtain a signed PCS from either the physician or practitioners relative to their peers.

Chapter 6, "Intermediary MR Guidelines for Specific Services," of the Medicare Program Integrity Manual contains medical review instructions for ambulance services.

30.2 - Supplemental Documentation Required on Intermediary Claims

(Rev.)

PM B-02-048

The provider must furnish the following data in accordance with intermediary instructions:

- A detailed statement of the condition necessitating the ambulance service;
- A statement indicating whether the patient was admitted as an inpatient. If yes the name and address of the facility must be shown;
- Name and address of certifying physician;
- Name and address of physician ordering service if other than certifying physician;
- POP (identify place and completed address);
- Destination (identify place and complete address);
- Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance);
- Cost per mile;
- Mileage charge;
- Minimum or base charge; and
- Charge for special items or services and an explanation.

40 - Carrier Disclosure to Suppliers

(Rev.)

PM B-02-048

Beginning February 28, 2003, and continuing through 2005 (the transition period) carriers must disclose to each ambulance supplier the supplier's reasonable charge allowance for the forthcoming year (e.g., the full amount that would have been payable under reasonable charge for all ambulance services). Carriers must:

- For each supplier, prepare a reasonable charge disclosure package that includes, at a minimum, the reasonable charge amounts for each procedure code that the

supplier is eligible to bill. Carriers do not need to disclose the reasonable charge amount for procedure codes that the supplier does not routinely bill. The disclosure package may include other reasonable charge amounts (e.g., prevailing rate, prevailing IIC, customary charge, customary IIC). However, carriers must indicate the reasonable charge allowed amount, e.g., the principle payment amount of the prevailing, prevailing IIC, customary, or customary IIC, and the corresponding HCPCS code.

- Provide the data for only those procedure codes that apply to each supplier's particular billing method. For Method 2 and Method 3 ambulance suppliers, carriers provide the reasonable charge amounts for codes A0425 through A0436. If providing the reasonable charge amounts for the old HCPCS codes, carriers use A0300 - A0370 and provide a crosswalk to the new codes. For Method 3 and 4 suppliers, carriers also include the applicable item/supply codes (e.g., the reasonable charge amounts for A0384, A0392, A0394, A0396 and A0398).

- Wherever possible, use the new HCPCS codes. They must clearly indicate that the corresponding amounts are the full reasonable charge amounts, e.g., the 100 percent reasonable charge amounts, and specify what portion of the charge is reimbursable within the current transition year. (For 2002, 80 percent of the total reasonable charge amount is reimbursable.) If old or deleted HCPCS codes are used, carriers must include a crosswalk in the disclosure package that maps each HCPCS code to the new replacement procedure code. The crosswalk may be provided as part of the disclosure statement or as a separate insert included as an enclosure with the disclosure.

- Send each supplier its disclosure package in accordance with the timetable specified in requirement 3 below. Publication of the reasonable charge disclosure is contingent upon the release of the ambulance inflation factor (AIF). If multiple AIFs are issued in the same calendar year, carriers must prepare a separate disclosure package to notify suppliers of the appropriate amounts and dates of service for each AIF.

- Assure that ambulance suppliers are aware of the ambulance fee schedule yearly payment blend percentages and the location of the ambulance fee schedule on the CMS Web site http://www.cms.hhs.gov/medlearn/refamb.asp.

Carriers must adhere to the following schedule of disclosure activities:

- **For CY 2003, on or before February 28, 2003 -** Mail to each ambulance supplier, the supplier's 2002 reasonable charge allowance, updated by the 2003 AIF. If applicable, include a crosswalk that maps each HCPCS code to the new replacement procedure code.

  (**NOTE:** Publication of the reasonable charge disclosure is contingent upon the release of the AIF.)

- **For CY 2004, on or before December 31, 2003 -** Mail to each ambulance supplier, the supplier's reasonable charge allowance for 2003, updated by the 2004 AIF. If applicable, include a crosswalk that maps each HCPCS code to the new replacement procedure code.

  (**NOTE:** Publication of the reasonable charge disclosure is contingent upon the release of the AIF.)

- **For CY 2005, on or before December 31, 2004 -** Mail to each ambulance supplier, the supplier's reasonable charge allowance for 2004, updated by the 2005 AIF. If applicable, include a crosswalk that maps each HCPCS code to the new replacement procedure code.

(**NOTE:** Publication of the reasonable charge disclosure is contingent upon the release of the AIF.)